FEBRUARY 1954

Mental Hospitals

Volume 5 Number 2

in this issue:

The Ceramics Workshop at VA Hospital, Perry Pt., Md. This is an initial step towards Member-Employee status.

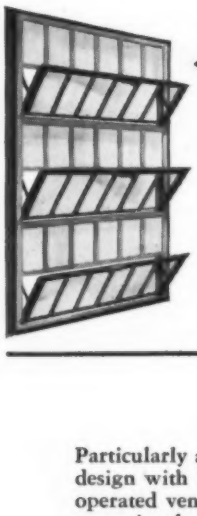
Published by
AMERICAN PSYCHIATRIC ASSOCIATION

WHICH OF THESE

TRUSCON STEEL WINDOWS

fit your detention needs?

All are detention-proved and safe. All are carefully engineered to protect mental patients against self-injury, and to conceal or minimize every indication of enforced restraint. All have extra margins of safety, allowing the use of large total glass and ventilating areas for abundant healing sunlight and fresh air. Truscon Steel Detention Windows are custom-built to meet your specific needs. Competent technical assistance is always available to help solve your particular window problem. Shown below are only three of the many Truscon detention window designs currently available. Write for your personal copy of the complete Truscon Window Catalog.



PSYCHIATRIC WINDOW

Suitable for detention of patients who are not inclined toward self-injury. Full 100% ventilation where desired. For example, window shown offers 50% ventilation. Degree of ventilator swing is controlled by limit stops. Furnished with bronze cam-acting locking handle, or concealed cam latch with removable key. Screens available for installation on the exterior side.

INTERMEDIATE LOUVER WINDOW

Particularly applicable to the needs of mental hospitals. Awning type design with 100% ventilation. Degree of opening of simultaneously operated vents is controlled with small removable crank, permitting operation by authorized attendant only. Principal restriction against injury or escape of patient is provided by detention screen opened only by removable key, also carried by attendant.

MAXIM-AIR® WINDOW

Suitable for use in mental institutions where moderate restraint will suffice. Awning type, with 100% ventilation as standard. Available in single, double or triple designs, built integral and controlled with a single operating handle. Size of vents and degree of opening may be designed to meet any requirement. For rooms housing violent patients, restraint and protection from injury may be further provided by detention screens.

TRUSCON® STEEL DIVISION REPUBLIC STEEL CORPORATION

1112 ALBERT STREET • YOUNGSTOWN 1, OHIO

TRUSCON'S STEEL WINDOW LINE INCLUDES ALL CONVENTIONAL TYPES PLUS EXCLUSIVE TRUSCON DESIGNS

THIS MONTH'S COVER

For patients who have been hospitalized many years, O.T. frequently becomes "busy work;" as the patient's incentive to produce diminishes with time, so does the therapeutic potentiality of craft work. Thus, while our range of craft activities is sufficiently varied to interest active treatment patients, we realized that some tangible impetus was needed to motivate the chronic regressed patients.

The annual poppy-making project sponsored by the Veterans of Foreign Wars and the American Legion, which pays the patients on a piecework basis, provided the clue. Many long-term patients who merely participated passively or even spurned regular O.T. activities would work diligently at this money-making—and therefore "purposeful"—activity. But the poppy-making project lasts only a few months, and the patients immediately lapsed back into inactivity.

The Ceramics Workshop project, which was begun in February 1953 at the VA Hospital, Perry Point, Md., provides a year-round purposeful activity. In addition, it is set up so that the Workshop participants are an interdependent group. The amount of money a patient earns depends on the total output of the group as well as on his own level of skill. Each task is rated according to its complexity and is assigned a commensurate number of "salary shares". The simpler jobs, for instance, such as janitorial duties or pouring the clay slip, have one share. The highest number of shares per job is four. In this category are the shipping and supply clerks, glazers, kiln supervisors and inspectors. Altogether, the Workshop has about 44 graded workers, plus an unlimited number of decorators who are rewarded on a piecework basis.

The finished products are marketed by volunteer service organizations. (In accordance with VA policy, no VA personnel are involved in handling or disbursing the funds.) Fifty percent of the gross profit is used to buy supplies, as the project is entirely self-supporting not counting the salaries of therapists. The other fifty percent is divided into salary shares for the Workshop participants. These are paid out bi-weekly. No participant receives more than $5.00 a week so that the incentive remains to progress to Member-Employee status (see MENTAL HOSPITALS, September 1953), and eventual discharge to outside employment.

Although the Ceramics Workshop resembles a small commercial pottery, there is no pressure on the patient-worker to produce. The ceramic product has value in our eyes only if the making of it helps the patient. When we see patients who previously were withdrawn or hallucinating now working together, accepting and offering each other suggestions, we feel this project is one of the most significant experiences we have known in many years of working with mentally ill patients.

Kathleen Anderson, O.T.R.
Perry Point (Md.) VA Hospital

Mental Hospitals

February 1954
Volume 5 Number 2

Copyright 1954
American Psychiatric Association

CONTENTS:

Published monthly, 10 times a year, September through June, for staff members of mental hospitals, schools and related institutions which subscribe to the American Psychiatric Association Mental Hospital Service. Institutional subscription rate $2.50 a year. Individual subscription rate for staff members of subscribing institutions, $2.50 a year. Published by the American Psychiatric Association Mental Hospital Service, 1785 Massachusetts Avenue, N. W., Washington, D. C. Entered as Second Class mail matter, August 1st, 1952, at the Post Office, Washington, D. C., under act of March 3, 1879.

A.P.A. OFFICERS:
Kenneth E. Appel, M.D., President; Arthur P. Noyes, M.D., President-Elect; R. Finley Gayle, Jr., M.D., Secretary; Howard W. Potter, M.D., Treasurer.

MENTAL HOSPITAL SERVICE CONSULTANTS:
Winfred Overholser, M.D., Chief Consultant; Walter H. Baer, M.D.; Addison M. Duval, M.D.; Granville L. Jones, M.D.; George E. Reed, M.D.; G. Wilse Robinson, Jr., M.D.; Harvey J. Tompkins, M.D.; Mesrop A. Tarumianz, M.D.; Gale H. Walker, M.D.; Mr. Carl E. Applegate; Mr. R. Bruce Dunlap; Mr. Robert H. Klein.

MENTAL HOSPITAL SERVICE STAFF:
Daniel Blain, M.D., Director & Editor of MENTAL HOSPITALS: John L. Smalldon, M.D., Director, Alston G. Guttersen, Architect, Architectural Study Project. Robert L. Robinson, M.A. Executive Associate; Pat Vosburgh, Chief, Editorial Dept., Elizabeth A. Keenan, Asst.; Jean Fitzsimmons, B.A. Advertising; Winifred Reim, Administration. Assisted by Ralph M. Chambers, M.D. Chief Inspector, and Frederick L. McDaniel, M.D., A.P.A. Central Inspection Board; Austin Davies, Ph.B., A.P.A. Executive Assistant; Elsie C. Ogilvie, R.N., A.P.A. Nursing Consultant, M.H.S. Regional Representatives and Contributing Editors.

Dancing Helps Patients Make Initial Contacts

When mental patients dance, they feel free to express themselves as individuals within the group. (Miss Chace in dark costume.)

By MARIAN CHACE
Director of Music & the Dance, St. Elizabeths Hospital, Washington, D. C.

Since the beginning of history, rhythmic action with his fellows has given man an awareness of himself as an individual. More than that, he has felt himself for the moment a part of the group, with mutual understanding and warmth. Dance, man's basic form of communication, is a way for a mental patient to make initial contact with others, to get support from the group and finally a means by which the patient becomes more aware of himself as an entity functioning with others in comparative safety. Is it any wonder that after dancing in a group for a few minutes, a patient will spontaneously stretch both arms and say "I feel so good"?

Let a nurse, an aide or a volunteer go on a closed ward with a phonograph or play some dance music on a piano or guitar while another shows readiness to dance, and a regressed patient will suddenly start waltzing; another will join in, and another, until the whole room is in rhythm. The patients, responding to an instinct as old as man, have spontaneously started moving their own bodies in rhythm to the music. They are using the music in their own way, for their own needs.

Problem of Providing "Free" Activities

One problem in the care of mental hospital patients is that of providing a day to day schedule of activity. Many factors contribute to the almost universal problem of habitually inactive and withdrawn patients. This situation exists even in private hospitals where the ratio of personnel to patients is comparatively large, and is almost an insurmountable problem in public hospitals, where the staff ratio is necessarily small.

The majority of activities require equipment which must be under careful watch by trained workers. In many wards the use of small objects or sharp tools is prohibited for the safety of the people living there. These tools must be used in shops or on wards where people are not too impulsive or unpredictable in their actions.

But on wards where the patients either have very little initiative or are restless with short spans of attention, boredom is a problem with which nurses and aides must constantly cope. Ward duties fill short periods for a few. But for many, there are days on end with almost no activity. Radio and television are passive activities

As one watches these patients —very sick, psychotic patients— and Miss Chace dancing, one gains the impression that through this medium the patients have at last found it possible to step out of their constricted world and, quoting one of them, "to reach outward." Their movements seem free, easy, comfortable; they undulate, flow, and appear to express in motion and rhythm what they cannot express in words or in conventional social actions. That they can do this is a tribute to the unusual qualities of Miss Chace as a Dance Therapist but it is also a reminder to us that there are few, if any, really "inaccessible" patients.

Jay L. Hoffman, M.D.
First Assistant Physician
Saint Elizabeths Hospital

during which a patient may remain absorbed in his own feelings. Card games and reading fill much time, but not days that add up to weeks or even months. Just sitting can become a habit pattern too difficult to alter even when an opportunity to do something else presents itself.

Yet talk with the ward personnel of any mental hospital, and they are eager to tell you of the enthusiasm of the patients for the social dances held in the recreation halls. They tell you that this is one activity which needs no over-urging or coercion for patient participation. It is, they add, a severe disappointment for any patient to be left off the list. Yet these dances can be held only once a week, once in two weeks or once a month. Only patients who can tolerate a large group for a fairly long time with limited supervision can be allowed to go.

Why not break the habitual ward lethargy by dancing on the ward too? Since there is this eagerness to dance, why not make use of it in a constructive way? Many hours of relaxation can be enjoyed both by patients and personnel even without the guidance of a trained leader.

Group dancing is satisfying, not only to those taking part in the dance, but also as a passive recreation. Rhythmic action when watched is felt by the onlookers in their own musculatures. Eyes lift toward the dancers, bodies noticeably relax, and smiles appear. Suddenly another patient leaves her chair at the back of the room to join the circle of people stretching their bodies and then relaxing in time to the music. It is not the urging of the leader. It is the contagion of rhythmic body action which draws her into the circle. She has made a beginning toward living and the enjoyment with others of this living.

If dancing is a part of the recreation program of her hospital, she will progress from occasional ward dances to modern dance sessions in a room used only for this purpose and then to other forms of dance of her own choosing. The role which dancing plays for her may change as she becomes ready to leave the hospital. Other activities will absorb more of her time and interest, and dancing will take its place as a medium for better body control, as a creative outlet or for social contacts, just as it might in the world outside the hospital.

Dance sessions in a mental hospital seem most valuable for the acutely ill patients and for those who remain for longer periods and who are unable to make use of activities which require verbalization, competition and individual initiative. Dance is a means of relating when other means are either restricted or absent.

Laying Authority Aside

The most difficult problem for the leader, trained or untrained, in organizing dance sessions is to grant the patients complete freedom of action. Since the structure of any hospital requires many regulations for the comfort of the majority of people, it may be hard for her to accept any and all action happening in response to the music. But since she herself must take part actively and with personal enjoyment and satisfaction, she must lay aside authority and become a relaxed participant so that patients may freely express their basic emotions through rhythmic action.

Chaos will not result, though if a

▼ *"Now I can reach out for myself."*

"Dancing breaks the ice in my feelings."

stranger entered a session during the early part, he might feel that it had. As I am moving somewhere in the room dancing alone or with one or more patients, I have often seen a nurse or attendant take several minutes to find me in spite of my attempts to signal her in a way which will not break the action. This means that the dancing does not stem totally from my leadership. Yet out of this free expression organized activity can be developed under leadership.

Acceptance of Patients' Interpretations

Working with patients in a dance session is not working in an artificial medium, but in a very real and very primitive one. A trained leader can use this natural response to music in many ways, but it can also be used to advantage by ward personnel and volunteers who have less training but who share, as do we all, the natural love of rhythm. It is an exciting and stimulating experience for a leader to share the feeling of rapport with patients who respond to music with the rhythm of their own bodies.

The acceptance of the patients' own interpretations of the music is essential to dance as therapy. If people are allowed freedom to dance as they wish, they are as spontaneous and rhythmic as young children. But with a leader who is rigid and insistent on her own patterns and style of movement, they will withdraw from contact with others just as they do in other activities. Given complete freedom of expression, they will soon form a group which can progress to composing dances together to which they all feel they have contributed from themselves and in which they find enjoyment in working together, accepting the discipline from themselves rather than from a leader's demands.

From Personal Forms to Group's Choice

One patient for instance may have dressed herself in a Hawaiian skirt with a Spanish shawl, while she twirls and stamps her feet in rhythm, apparently oblivious to everything about her except the rhythm and the materials whipping around her. Yet with no word of suggestion, she will discard her elaborate costume and be one of the first to join the circle which is forming to dance simple, rhythmic actions in unison. She has been accepted in her own forms. Now she can accept those of the group.

Or take the unpredictable patient, given to sudden physical assaults who cannot usually share activities without someone to devote exclusive attention to her. Because of the natural fear of being hurt, many people avoid close contact with her. When she hears music, she will dance spontaneously, though in her own style. She is not yet able to take part in a dance session with conventional forms of social dancing. But if no stress is placed on the way she "should" dance, she will be able to remain with the leader and other patients for the full session. During this time, she may dance alone, with a group in a circle, with the leader alone and perhaps with another patient. She may occasionally relax in a chair, watching others dance and remain relaxed for some time after the session. The leader will find it truly fun to follow this patient's lead in her buoyant, original dance patterns and will feel empathy with her response to the music. It is satisfying not only to the patient herself but to the others to be able to feel companionship with her rather than a withdrawal.

Whether she is trained or untrained, the leader must use her own judgment as to when she should attempt gently to get the patients to develop groups. It is usually when the room is almost totally in action but before pandemonium reigns. Small circles of varying individuals are formed, separate and re-form. Leadership passes back and forth from members of the groups to the leader and her assistants. As the people involved separate less frequently, verbal communication begins to develop and gradually replaces relating by movement alone.

I frequently end a group, especially of over-active patients, with fifteen or twenty minutes of contemplative music. A Bach Brandenburg Concerto is one of the favorites. The patients sit or lie in close groups without body contact and there is no noise from voices. Occasionally a single patient may use the music to dance some feeling of tragedy or exaltation, but this never seems to disturb the relaxed quiet of the rest of the group.

Editor's Note: *These pictures, taken at St. Elizabeths Hospital, were done with the knowledge and cooperation of the patients. The dancing was "stopped" by the photographer for each picture, and the patients themselves selected the results based on their opinion of the significance of the varying attitudes. Some of their comments are used with two of the pictures. Although these pictures show women, men enjoy dance therapy as well.*

Miss Chace, herself a professional dancer and dance teacher, came into psychiatry when she worked as a volunteer teaching dancing at St. Elizabeths in 1942. She became a full-time dance therapist as a Red Cross worker in 1944, and in 1947 joined the therapy staff of the hospital. She also directs dance therapy and psychodrama at Chestnut Lodge Sanitarium, Rockville, Md.

She is a member of the National Association for Music Therapy and Chairman of the Modern Dance Council at Washington, D. C. In addition to her musical and professional dancing education, Miss Chace has studied at the Washington School of Psychiatry.

Miss Chace has given M.H.S. a list of the records she uses and this will be sent to any hospital on request.

ARCHITECTURAL STUDY

Field Work and Further Plans

By JOHN L. SMALLDON, M. D.
Director, Architectural Study Project

We are pleased to announce that since the publication of a list of the project's consultants last month, there has been the addition of two highly qualified architects, who were appointed to the committee by the American Institute of Architects.

John Reinhold Magney, A.I.A., Minneapolis, Minn.

Joseph M. Neufeld, A.I.A., New York, N. Y.

Mr. Magney is identified with a middle west architectural firm which has been successful in designing a number of modern, functionally efficient mental hospital buildings in Minnesota and elsewhere. The addition of Mr. Neufeld to the group brings the advice of an architect whose work in mental hospital design is international in scope and who is doing important progressive work in the field as a visiting professor on the faculty of the Yale School of Architecture.

Last month's preliminary report of our survey of new construction in public mental hospitals since 1946 and of plans for construction in the next five years was considered to be a remarkable response indicative of a nationwide interest in mental hospital design, construction and equipment. The survey is now complete and replies have now been tabulated from 151 public hospitals in 46 states. The final data in part is as follows:

Complete Mental Hospitals—

Opened since 1946	3
Under Construction	3
Planned in next 5 years	2

Receiving and Intensive Treatment Buildings—

Built since 1946	59
Under construction	4
Planned in next 5 years	19

Geriatric Buildings—

Built since 1946	58
Under construction	2
Planned in next 5 years	15

Medical and Surgical Buildings—

Built since 1946	28
Under construction	4
Planned in next 5 years	11

Continued Treatment Buildings—

Built since 1946	74
Under construction	9
Planned in next 5 years	62

Convalescent Buildings—

Built since 1946	18
Under construction	2
Planned in next 5 years	4

Disturbed Buildings—

Built since 1946	21
Under construction	8
Planned in next 5 years	8

As cards of inquiry were sent to 194 hospitals and 151 of these replied, the survey is approximately 77% effective. It is obvious that although a great deal more modern construction is needed in addition to that reported, the amount planned for the next five years is an indication of the need for this study. If our project can be of service even to those hospitals reporting present plans for construction, our collaborative planning should result in modern, well-designed hospital buildings throughout the North American Continent which will play an important part in improving the efficiency of mental hospital treatment.

If you have a mental hospital building project with which you wish assistance. this office will count it a privilege to attempt to provide that assistance.

We are beginning to hear from psychiatrists who are willing to undertake studies of particular types of mental hospital buildings in their areas, working on psychiatrist-architect teams with the assistance of check-lists soon to be ready for distribution from this office. We hope to receive many more offers of assistance.

Are you experienced with, or interested in a particular building type, for instance receiving and intensive treatment buildings or buildings for disturbed patients, and will you volunteer your help in this phase of the study?

ARCHITECTURAL & MEDICAL CONSULTANTS AT EARLY MEETING

L. to R.: Dr. Harvey J. Tompkins, Mr. Alston G. Guttersen, Dr. Addison M. Duval (Chairman), Dr. Winfred Overholser, Dr. John L. Smalldon, Mr. Slocum Kingsbury, A.I.A., Mr. Moreland Griffith Smith, A.I.A.

Elements of the Intensive Treatment & Receiving Building

By ALSTON G. GUTTERSEN
Architect to the A.P.A.-M.H.S. Architectural Study

The receiving and intensive treatment service of the state mental hospital should be located near the main entrance to the hospital, removed from the continued treatment patient and geriatric patient area, and conveniently located with respect to the medical and surgical building. While some new patients may be required to go to the medical and surgical building for special diagnostic or treatment procedures, and others may go to central occupational and recreational therapy facilities, nevertheless, this service should be sufficiently complete in diagnostic and supporting therapeutic facilities to provide treatment of new ambulant patients without contact with the main mental hospital population. This requires a duplication of some facilities of the complete mental hospital, but it permits a control of the therapeutic environment and activities which are not possible when contact with chronic mentally or physically ill patients is made.

Under modern treatment programs, rapid improvement of patients is frequent. To quote Dr. Eugene E. Elder, ". . . we recall how a manic patient spent four to five months in hospitals. . . . In addition to this, acutely disturbed patients were always in restraint. How differently people are treated now. The manic period of extreme restlessness and noisiness quiets down in three to four days. . . ." A greater percentage of patients, therefore, may be permitted greater freedom and choice of activities. Care should be taken in the location and design to provide sufficient outdoor space for recreation with isolation from chronically ill patients to insure an encouraging atmosphere of recovery.

The administrative offices are grouped together in a separate area near the main entrance, convenient to the public and away from diagnostic and treatment areas and in-patient areas. The main elements of this administrative group are: main entrance lobby and waiting room, information counter, public toilets, public telephone, business office, medical record room, library and conference room, offices for chief psychiatrist, chief psychologist, chief psychiatric social worker, chief nurse, secretaries and admitting personnel, lockers and toilets, and janitor's closet. Additional offices for staff interviews and treatment are located near patient areas of the nursing units.

Where an out-patient service and/or day-care program are to be included, the chief psychologist, chief psychiatric social worker and staffs would be located in the out-patient area with the offices for the psychiatrists of this service.

The main entrance lobby and waiting room should be convenient to corridors leading to the out-patient department and the diagnostic facilities. Access to these facilities by the public should be easily observed and controlled from the information center. The lobby and waiting areas should have adequate space for seating as well as circulation to the various departments. It should have direct access to the cashier's counter or office and to the corridor leading to the chief psychiatrist's office, and should be visible from the information counter.

The information counter should be located to provide observation of the lobby, waiting area and corridors to administration, diagnostic and out-patient areas. In the small hospital the telephone and information facilities may be combined. In the larger hospitals, where these services are separate, it is desirable to locate the communication services and information counter adjacent to each other in order that the telephone operator may also serve the information counter during the night. The intercommunicating telephone system should connect all staff areas and may be automatic. The system may serve also as a fire signal. Public toilets and public telephone booths should be provided in a convenient location in or near the main lobby. Both should be under supervision of the information center.

The business office will contain the general office space for clerical staff and equipment, a vault for business records and a safe for patients' valuables. The office should be arranged with convenient access to the cashier facilities, which should be convenient to the lobby area. In larger hospitals separate offices are desirable for the auditing, purchasing and credit departments.

The medical record room should be accessible to the admitting room and out-patient department. It should be convenient also to the administration area. Space should be available in the room, or in an adjacent staff room, for work on medical records. In larger hospitals a pneumatic tube system for transportation of records to the various departments may be desirable.

A library and conference room should

be provided, preferably located adjacent to the medical record room. Where an out-patient service is included, it may be located in the out-patient department.

The chief psychiatrist's office should be accessible to all other offices, but located to insure privacy. Access to the room should be provided both from the corridor and from the secretaries' office. It should be large enough to serve as conference area for a small group. The secretaries' office should be large enough to serve as entrance to the psychiatrist's office with sufficient waiting space for a small group of people.

Offices for the chief psychologist and chief psychiatric social worker may be located in the out-patient department when that service is provided.

The chief nurse will be in charge of all nursing personnel. Her office should be near the administrator's, or chief psychiatrist's office, and large enough for conferences with three or four people. Larger conferences with nursing personnel will be held in the conference room. In larger hospitals there would be separate offices for an assistant and offices for secretaries.

Diagnostic Facilities

The intent in the receiving building is that it furnish diagnosis and treatment of new patients for return to the community without their having been a part of the main mental hospital population. Since receiving buildings having this service are relatively new, their pattern of requirements has not been clearly established. This is particularly true regarding the amount of diagnostic equipment to be included in this facility.

Analysis of the treatment program establishes the fact that duplication of routine diagnostic equipment in the total hospital is justified in many instances, according to both the American Psychiatric Association standards and Public Health Service regulations. The medical and surgical facility serves the entire hospital community in the same manner that a general hospital serves any community. As such it serves the physically ill bed patients. It also furnishes out-patient medical services to the hospital community. It serves only those new patients who are physically ill or who may need more complete examination as indicated in the routine diagnosis.

In the receiving service an active program of therapy is begun with each individual upon his entering the hospital, and diagnoses are continually being made during the course of his treatment. Areas for programs in work, in recreation, in socialization and, at times, for uncontrolled self-expression in activity are required. These programs cannot conveniently or therapeutically be accomplished within the general hospital setting where the bed is the place of treatment and quiet surroundings are required.

New facilities are being constructed in which the receiving building is entirely separate from the main mental hospital population and in which, in some cases, routine diagnostic equipment is included. Also, new facilities are being constructed in which new patients are being admitted to the same building in which the general hospital facilities are located. This is being done for the convenience of having new patients, who require routine diagnosis, near the diagnostic facility to avoid duplication of facilities. Also for convenience, then, the convalescing patients, who are part of the receiving service, are located here; in addition, and for the same reason, the chronic physically ill patients who need careful nursing and considerable medical attention are in nursing units in this building. The result has been, in some cases, that 400 to 500 such patients, both ambulant and non-ambulant, have been housed in close proximity, in large buildings which have little chance of providing an acceptable situation for individual needs.

In planning new facilities there is sufficient evidence to support the program of intensive treatment of new patients separate from the other services of the hospital. In order to accomplish this, facilities for an initial routine diagnosis should be included. These are doctor's office and admitting room, medical examination and treatment room, x-ray room, laboratory or specimen room, EKG, B.M.R., EEG rooms, and dental facilities. Should some patients require more exhaustive diagnosis, they can be transferred temporarily, or conducted periodically to the general hospital.

These diagnostic facilities should be grouped together away from areas of patient activities and located between the out-patient department and the in-patient areas. The requirements for each of these facilities will be similar to those of general hospital facilities. The admitting room should be located adjacent to this suite, near the medical examination room.

In addition, facilities for insulin and electric shock treatment will be required in the receiving building. The amount of insulin and electric shock treatment given varies in different hospitals. Therefore, in programming requirements for this facility, consideration should be given not only to immediate requirements, but also to possible future requirements should the service be operated under a different staff. Insulin may be given, as is preferred by some, in the single room of the patient. It is usually given in a larger room where several patients may receive the treatment at some saving in staff. It may be desirable to plan for the latter, in which case the recommended facilities are as follows: waiting room or space; insulin treatment room for each sex; single bedroom with each insulin treatment room; nurses' work room; linen and blanket storage and patients' shower and toilet rooms. This arrangement is shown on the 40 to 50-bed plan.

The waiting space should be located to provide good observation from the nurses' station or work area, but in a manner that will not permit patients who are waiting for treatment to observe or hear patients who are receiving treatment or who are in recovery from electric shock. This waiting space would be used chiefly by patients who are to receive electric shock. Patients should be conducted to this area in small groups. It may be used by out-patients as well.

The insulin treatment room should have beds spaced so that they are easily wheeled in or out of the room. Space for treatment tables will also be required. The room should be arranged for good observation of all patients and for convenience in traffic to any bed. Patients who are receiving treatment will occupy the room for approximately four hours. In hot, humid climates, air conditioning of the room is desirable. If electric shock treatment is to be given in this suite, the insulin treatment room may be used as the recovery room. The recovery period from electric shock treatment is approximately 30 minutes.

The single room may be used for preparation of a patient before insulin treatment is started; for emergency treatment of difficult recovery cases and for electric shock treatment. It should be similar in size and equipment to a general hospital single-bed room.

The nurses' work room should be located with good observation of the waiting area, the insulin treatment rooms and the single-bed rooms. Its facilities should include an area for record keeping and a work area containing a sink with cabinets above and below for storage of treatment trays, utensils, etc.; refrigerator for storage of drugs and food; a counter for preparation of toast, orange juice, etc., and a double-element hot plate. Food must be served to the patient during the recovery period from insulin shock therapy.

Linen and blanket storage areas should be convenient to both suites.

Emergency receiving facilities are desirable for the occasionally disturbed patient. They will consist of a receiving bedroom with bath and toilet and a sub-utility. Temporary isolation for observation of new patients may sometimes be necessary also. This may be accomplished in the special facilities of the emergency receiving room or in special receiving and treatment rooms of each nursing unit. The latter is preferred.

Recreational and Occupational Therapy

Recreational and occupational programs are not new in mental hospitals. Today's programs of activities are, however, more scientific; they are no longer used solely for the amusement of the patient. All human beings, and particularly those with emotional or mental illness, need to achieve "something in the way of balanced activities. In a sense, the whole function of a mental hospital is to assist the patients to live leisurely rather than compulsively," says Dr. Alexander Reid Martin. Doctors have long ". . . urged the development of work-play, exercise-rest relationships in the regular day's living program", Dr. Austen Riggs corroborates.

Dr. Robert Hyde discusses the situation in the Boston Psychopathic Hospital as follows: "On each ward the patients have available within their reach, a variety of small games, a ping-pong table, a piano, a phonograph, a radio and a bookcase of recent magazines and books. All convalescent patients and all acutely ill patients with the prescription of their doctor spend three hours in the forenoon and three in the afternoon off the ward in what is called the Occupational Therapy Department. Here male and female patients are together. This department, in addition to the workshops, includes a large recreation room and a library which the patients use whenever they tire or have not yet become interested in work projects. In the recreation room there is the jukebox, piano, ping-pong table, and card tables, and there they can dance. In another recreation room a pool table is available. Television is available to all patients during all hours when regular programs are available. . . . There is an evening program every night of the week. Only on one of the seven nights are personnel present on duty solely for the supervision of the event."

Occupational and recreational therapy programs will be organized into activities on the nursing units, and in the central facilities. Additional occupational activities may be provided in useful work in the hospital, on the hospital grounds, and in the service shops.

For programs on the nursing units, the living rooms, screened porches and adjacent outdoor areas will be used. Closets, in or near these facilities for the storage of equipment, will be required. Chiefly those activities which require light equipment, such as sewing, typing, painting, card games, will be organized in the nursing units. For those activities requiring space or equipment of a special nature, central occupational and recreational therapy facilities will be used. These generally consist of occupational shop, with office for therapist and storerooms for storage of supplies; exercise gymnasium with locker and shower rooms for both men and women patients, office for therapist and equipment storage room; a canteen; and a hand laundry for women patients. The barber shop and beauty shop are generally located in this area. A library and reading room and a conference room for teaching are desirable.

The exercise gymnasium should be a minimum of approximately one-half of a basketball court for installation of a basketball backboard and basket. In general the least competitive activities will be used, though volley-ball, badminton, shuffleboard, ping-pong may be among the activities scheduled. Punching bags, tumbling mats, parallel bars, exercise pulleys, etc., are some of the equipment that will be used. The space should be arranged so that it may be used for motion pictures, plays, and dances. The gymnasium should open to outdoor exercise areas where tennis and ball games may be organized. Activities which require a larger or special space, such as bowling or billiards, will be located in the central recreational facility of the total mental hospital.

Locker and dressing, shower and toilet rooms for men and women patients should be located, when possible, to serve the occupational therapy shop also.

The office for the therapist should be located with observation of the gym floor and supervision of the locker rooms and equipment storage area. A coat closet and shower and toilet room should be provided adjacent to the office.

Storage space for all equipment which may be moved to clear the floor for larger group activities should be provided. If motion pictures are to be included as activities in the gymnasium, storage facilities for movable seats will be required.

The canteen, equipped to supply soft drinks, sandwiches, ice cream, coffee and possibly short orders for patients, relatives, friends and staff, is preferably located near the central recreational and occupational areas. It should be a well lighted attractive room, large enough for several groups of tables and chairs and provide an atmosphere of relaxation.

A survey of occupational therapy activities for all types of patients in hospitals throughout the country indicated that approximately seventy different activities were in use. A complete program of proposed activities should, therefore, be furnished the architect before sketches are started for this important facility.

The central occupational area will include office for therapist, preparation area for activities for nursing units, occupational therapy shops and storage.*

The shops will be organized into the general activity areas or rooms for bench work, equipment work, table work, loom work, painting and finishing space. Loom work will include weaving and braiding of several types of materials. Bench work will include work in carpentry, plastics and metal. Equipment space for saws and lathes should be in this area. Table work will include activities in leather work, sewing, typing, painting, sketching, modeling, block printing and ceramics. Water, gas and electric outlets should be provided.

Areas or rooms should be organized with ample space around equipment and for storage of work in process or of waste material. The larger service will have separate rooms for bench, table and loom work, ceramics, printing and painting.

Storage space will be in the form of shelves, cupboards and bins, above and below work areas or in special cabinets in the work area, and in a special storage room. Material to be stored will include both equipment and material for work in process and for general supply. Areas for the storage of paint should be constructed in accordance with the requirements of the local fire marshal.

The occupational therapist's office should preferably be near the entrance to the shop areas with good observation of the shop and storage areas. It should include a desk, work table, bookcase, filing cabinets, and two chairs. A clothes closet and toilet room should be adjacent.

For activities on the nursing units, mobile cabinets, containing materials and equipment, will be required. Space near the therapist's office should be available for the preparation and storage of these carts. The carts may be approximately 24" by 42" by 36" high.

A bulletin board, near the entrance door, should be provided.

Dietary Facilities

Many state mental hospitals have a central kitchen for the preparation and cooking of food for the total hospital, with a central dining room for all patients who may leave their cottage. For those patients who cannot, food is brought in bulk to a serving and dining facility in the particular cottage. In mental hospitals where food must be transported over long distances, a most serious complaint is that it becomes unpalatable by the time it reaches the patient. Food is most important in patient welfare and good will; serious study must be given to the food service to the various patient classifications.

---

* "Planning the Occupational Therapy Service," Wilma L. West, O.T.R. & Alonzo W. Clark, A.I.A., Journal of the American Hospital Assoc., Oct. 1951.

The receiving and intensive treatment facility should have a food service, insofar as cooking and serving is concerned, which is separate from the central food service. Supplies, prepared as required, should be obtained from the central storage and preparation facility, but cooking and final preparation for serving should be done at the receiving building. A dining room, or dining rooms, having cafeteria service, would then serve all cooperative ambulant patients from the receiving building and convalescent cottages. Where a day-care program is included, patients of this service would also be served here. For patients remaining in the nursing units of the receiving building and convalescent cottages, bulk food carts, insulated and heated, may be used to transfer food to the serving pantries of each nursing unit. Patients remaining in the nursing unit may be served in small dining rooms, or on facilities in a day room, or in their bedrooms.

The dining room and kitchen should be located for convenience of traffic flow of patients, of prepared bulk food to nursing units and of service roads to the kitchen. The service roads to kitchen should not interfere in the development of patient outdoor exercise and relaxation areas. These outdoor areas, to be most successful, should be located immediately adjacent to the nursing units. Improper location of service areas may prohibit their successful development. Where day-care programs are a part of the hospital services, it is desirable to have the kitchen and dining facilities between in-patient and out-patient areas.

Dining rooms should be quiet, uncrowded, well lighted and well ventilated. Cafeteria service, offering a choice of food, is recommended. Dining is an important item of therapy for all patients and every effort should be made to provide for this activity in an attractive, relaxed atmosphere. In planning the dining space some allowance for dining of staff with patients or groups of patients should be made as this may be desirable, particularly with the new patient. Most of the staff, however, may use the staff dining room of the hospital.

Efficient kitchen design is a highly specialized subject and employment of a competent kitchen engineer is desirable for detailed preparation of plans and equipment. For preliminary programming and planning suggestions reference may be made to material prepared for the general hospital by the Division of Hospital Facilities, Public Health Service.

Small Nursing Units Recommended

Nursing units are recommended to be designed for not more than 25 patients. They should be arranged for the segregation of patients of different classifications. In the larger service segregation for the various classifications is accomplished by having a nursing unit for each classification. In the smaller service, it is necessary to provide these separate areas in the same nursing unit. The nursing units of the smaller service are, therefore, more complex in arrangement as contact between patients of different classifications should be prohibited or controlled. Great flexibility is needed in the placing of patients as each must have an acceptable situation in which he may express his personality as it is in his illness, and under modern treatment programs, patient behavior improves rapidly. It is desirable to provide, in the receiving building, segregate areas for classifications of patients, as determined by behavior characteristics as follows: convalescent, quiet and cooperative, depressed, disturbed, suicidal and intermediate. Additional classifications, such as senile and arterio-sclerotic, are required. These may be in the adjacent convalescent cottages since their activities will be different from those of active patients.

The convalescent cottages, also containing nursing units of 25 beds, are considered a part of the receiving service. These cottages may house the senile and arterio-sclerotic patients for a period of approximately four weeks while their diagnosis is being completed or during the full course of treatment of those whose prognosis is favorable. They will also house additional patients of a convalescent classification who may live in an open situation, and groups of patients of a similar age, personality, illness, etc., who are under similar treatment programs. Says Dr. D. Ewen Cameron, "We have gone far in accepting the group as a factor in treatment. Not a group of a hundred — but of fifteen, twenty or twenty-five. This acceptance is being expressed in function. . . . We are building today not great masses of buildings, but small ones."

In the small service of only two nursing units of 25 beds each, it is possible to have separate bedroom and living room areas with each having access to separate outdoor areas for the principal classifications of convalescent, quiet-cooperative and disturbed. These can be arranged with good observation of each classification area from the nurses' station. With the use of double corridors, nursing units of 25 beds each have been devised with five separate areas, each having access to separate outdoor areas.

The major divisions of patient areas in the nursing unit for the receiving building will, then, be determined by the number of nursing units which are to be planned. The following points must be observed in all cases: direct access from living rooms of each patient classification to separate outdoor areas for recreation or relaxation; greater freedom for patients and greater opportunities for self-expression; greater possibilities for development of suitable occupational and recreational therapy and group activities.

Facilities of Nursing Units

Facilities within the nursing unit may be divided into (1) patient accommodations and (2) treatment facilities. It is desirable to separate treatment facilities from patient accommodations in order to provide an appropriate environment in the patient area, as patients who are engaged in recreational or occupational therapy, or relaxation should not be distracted by patients receiving special medical treatment. Comfortable and attractive surroundings in the patient area will encourage informal group discussions, occupational activities, reading and social activities with participation of families.

Facilities of the patient area include: bedrooms, living rooms with closets for occupational and recreational therapy equipment, toilet rooms, bath and shower rooms, a patients' laundry for women patients of the locked section, pantry, dining room or space, and a nurses' station.

Facilities of the treatment area of the small service include: psychiatrist's office and interview room, medical examination room, psychologists' office and visitors' rooms. A room for continuous bath and pack treatments may also be included in the disturbed patients' area, although neither treatment is used as much as formerly and opinions vary as to the need for these facilities in the small unit. In the larger service the additional facilities which are required may serve more than one nursing unit. Interview rooms for use by psychiatrists, psychologists and psychiatric social workers should be provided in the ratio of a minimum of one room to each ten patients. Receiving and special treatment bedrooms, insulin treatment suites and a staff conference room are desirable in the larger service.

Facilities in the nursing units which should be convenient to both the patient area and the treatment area are: utility room, linen closet, supply closet, janitor's closet, stretcher closet, patients' clothes room and attendant's toilet.

Bedrooms

"Psychiatric patients generally have been non-assertive, sensitive people who have difficulty in finding a life and place in group living. As they have much diffi-

culty in relating to a group, and even trouble in individual relationships, it is advantageous to have single sleeping units where they can have privacy and a place they can consider their own," recommends Dr. Leslie A. Osborn.

Two-bed rooms, however, may be used in the open section for the convalescing patients, and some may be specified for quiet patients of the closed section, though approximately 60 per cent of the beds of the closed section should be in single rooms. Single rooms are required for disturbed patients, though in the large service, some four-bed rooms may be used. Single and four-bed rooms are desirable for depressed patients. Two-bed rooms are unsatisfactory on the psychiatric service, except for convalescing patients. One-bed, two-bed and four-bed rooms for the open section may be small and furnished with studio type (or low) beds.

Bedrooms for the closed section should be designed in accordance with the principles of psychiatric safety. There should be no projections of structure, piping, sharp corners, etc., on which an excited patient may injure himself. A simple room, all of which can be seen at a glance, is desirable.

Seventy sq. ft. per bed in alcoves and four-bed or more rooms and eighty sq. ft. in single rooms is the minimum desirable size for bedrooms according to Public Health Service Regulations.

Approximately 10 per cent of the bedrooms for quiet patients should have private bath with tub, as these will be required in the treatment program for some patients.

Clothes closets should be furnished in all bedrooms of the open section and for the quiet patients of the closed section. They are desirable in rooms for depressed and disturbed patients, though the closet doors should open into the corridor rather than the room. The nurse would retain the key for depressed and disturbed patients' closets.

Living Rooms

Living rooms should be comfortable and attractively furnished for informal activities of relaxation, reading, group discussion, writing, etc. There should be at least two, one small and one large, for each nursing unit. Where more than one classification of patient is to be in a single nursing unit, however, there should be a living room for each classification. This will provide the necessary flexibility of use by patients of different sex, behavior, age, activities. The larger living rooms should have large closets for storage of occupational and recreational therapy equipment for the more organized activities. If one-story construction is used, living rooms should open directly to separate outdoor areas for recreation. Living room area for nursing units is recommended to be from 40 to 50 sq. ft. per patient.

Toilet and Bathroom Units

Toilet and bathroom facilities for the open section and for quiet, cooperative patients are similar to those for medical and surgical nursing units. Toilet and bathroom facilities for the closed section should be designed in accordance with the principles of psychiatric safety. Toilet facilities for convalescent and quiet, cooperative patients may be furnished with the bedrooms, or may be central in the nursing unit, though facilities should be arranged for privacy.

Toilet spaces for the disturbed and depressed patients' area should be larger than for less confused or excited patients. Water closet stalls should be of sturdy construction. The top of doors to water closet stalls should be approximately 4 ft. 6 in. from the floor and the bottom approximately 18 in. from the floor. They should swing out and have no provision for locking. In the larger service, the hospital administrator may prefer that stall doors not be used. Water closets should be of the flush valve type with automatic flushing. The seat for the water closet should be reinforced.

Lavatories in the disturbed and depressed patients area may be of the institutional type and preferably having concealed supplies and trap though they may have exposed trap and keyed supplies. The faucets should be sturdy. Mirrors should be of heat tempered glass. Shelves, rather than hooks, for towels, soap containers, etc., should be provided, and recessed into the tile walls.

Water closet and lavatory rooms should be arranged for ease of observation while still affording the patient as much privacy as is compatible with safety.

Showers, for the closed section, are recommended to be approximately 3 ft. wide by 5 ft. long. Institutional type shower heads are recommended and it is desirable to place these in the entrance lintel to the shower stall. The controls should be placed outside the shower stall. The lintel over the entrance should extend to the ceiling. A hand grip, recessed into the wall, is desirable. Dressing areas should be provided.

Patients' Laundry

Women patients will require a facility for the handwashing of personal garments. A small room in the nursing unit, near the day activity areas, should be equipped with laundry tubs, drying cabinets and ironing boards.

Patients' Clothes Locker Room

Mental patients stay in hospital much longer than medical and surgical patients. They will, therefore, need a large wardrobe with variety of clothing, including any special garments needed for their occupational and recreational treatment programs. Therefore, a clothes locker will be needed on each nursing unit for those articles which cannot be kept in the closets of the patients' bedrooms. The locker should be located near the entrance of the nursing unit. In addition to lockers for each patient, there should be luggage space and a table with equipment for the careful marking of all clothes and personal articles.

Food Service and Miscellaneous

A serving pantry will be necessary in each nursing unit and a small dining room may be desirable on some nursing units, especially for disturbed patients.

In examination and treatment rooms, interview rooms, utility rooms, floor pantry, flower room, linen and supply closets, stretcher closet, janitor's closet, the principles of psychiatric safety must be observed as to locks, door swings, window protection, etc., in the closed section. If linen chutes are provided, they should be located within a room off the corridor. No areas, such as the stretcher closet, shall be left open, but shall have doors which swing into the corridor, and be able to be locked from the outside only.

Nurses' Station

Nurses' stations in the closed section should be enclosed and located to provide good observation of corridors and living rooms. Most designs show these enclosed with glass to provide unobstructed observation. This design has the added advantage that many patients will be reassured if they are able to see a nurse at all times.

It should be remembered, however, that privacy for the nursing staff is required in the medical preparation area and in the area for record making, conferences, telephone, etc. An ideal arrangement for a nurses' station would include the charting counter area, glazed and projecting into the corridor and adjacent to a living room for good observation, a separate small medical preparation area and an adjacent interview room for use by the staff only. The nurses' toilet should be nearby.

It is also desirable to provide a single or four-bed room adjacent to the nurses' station for continuous observation of patients. Glass used for enclosing the nurses' station or for observation panels should be heat tempered.

In nurses' stations for open sections, privacy of records must always be insured.

Receiving and Special Treatment Bedrooms

Some new, quiet patients may have difficulty in adjusting to the hospital atmosphere. Also, some patients may be in need of special treatment or observation which may be better conducted out of the patients' living area. For this reason, one or two-bed rooms with private bath and sub-utility are advisable in the treatment area of each nursing unit. They will be used in administering many treatments requiring isolation such as fever treatment, narcosis, electric shock, etc.

If one of these rooms is enlarged to four or more bed capacity, it may be used for insulin treatment. The amount of insulin treatment varies in hospitals. It is best administered in the patient's bedroom, but since constant and careful nursing is needed for approximately four hours, additional central insulin facilities are recommended. A small utility room for preparation and a room for difficult recoveries should be included nearby.

The small service will probably not be able to provide a special insulin treatment room and may use a four-bed room for this purpose.

If hydrotherapy is to be included, two tubs may be sufficient in the small unit. Since continuous flow bath treatments cannot be scheduled, there must be separate suites for men and women patients. Approximately 50 percent of the nursing units of the convalescent cottages are recommended to have a continuous flow bathtub. Those will not be used by disturbed patients, but by neurotic patients who may benefit by this relaxing, sedative hydrotherapy.

Tubs should be placed a minimum of three ft. six in. from the wall. Where more than one tub is to be in a room, the tubs should be placed a minimum of eight ft. on center. In the large service which has several tubs, some single tub rooms, for use by noisy patients, should be provided.

Pack treatment may be given on movable or fixed tables. Tables should be a minimum of eight ft. on center and three ft. six in. from the wall. In the small unit pack treatment may be given in the tub room, on a wheel treatment stretcher with wheel locks, or in a single-bed room.

Linen and blanket closets, laundry tub, ice bin for compresses and blanket warmer should be included in the area for continuous flow bath and pack treatment. Where stimulative salt rub treatments are given, a hydrotherapy shower would also be required; so will water closets and dressing rooms.

Continuous flow bath and pack treatment rooms should be adjacent to disturbed patients' bedroom areas, and accessible to patients of other classifications.

Other Facilities

The examination and treatment rooms, interview rooms, utility rooms, floor pantry, flower room, linen and supply closets, stretcher closet and janitor's closet may be as specified for medical and surgical nursing units,* except that the principles of psychiatric safety must be observed as to locks, door swings, window protection, etc., in the closed section. If linen chutes are provided, they should be located within a room off the corridor. No areas, such as the stretcher closet, should be left open, but should have doors which swing into the corridor, and be able to be locked from the outside only.

Entrance Halls

Where main stair or elevator lobbies are required, they should be convenient to, but not within, the nursing unit. They should be accessible from patient areas only through locked doors. Stair halls should be completely enclosed and be able to be locked. Stair walls, or balusters, should be continuous from stair to stair and not stop at the handrail. While all security and safety measures should be observed in entrance and stair lobbies, they should be unobtrusive. The area should be attractive and reassuring, as first impressions of the hospital may be formed at this point. Where receiving buildings are of one-story construction, they can more readily be arranged to develop the required programs of activities which any modern treatment program will include.

Visitors' rooms should be adjacent to, but outside the nursing unit. They should be attractive rooms, comfortably furnished and arranged to provide privacy for two or three groups of patients and visitors.

General Arrangement—Small Unit

The larger psychiatric services, having several nursing units, each one of which is designed for a particular patient classification, can be comparatively simple in arrangement. Patient living areas can be easily separated from treatment areas. It is the small service of 20 to 25 beds having facilities for several patient classifications that is difficult to design, as it is desirable to prohibit or limit contact between patients of difficult classifications, yet provide living and recreation space.

* "Elements of the General Hospital," Division of Hospital Facilities, Public Health Service.

Materials and Finishes for the Closed Section

The degree of safety and security required throughout the receiving and intensive treatment building and the adjacent convalescent cottages may be determined by many factors which will vary with each institution. A modern service providing an active medical program with adequate staff and supported with a variety of therapies in occupation, recreation, etc., will require much less security than will the custodial service. Also, the type of buildings which are provided will have their effect on patient reactions. Those designs which provide for easy segregation of patients of different age, personalities, behavior, etc., and for flexibility in the placing of patients and those which provide patients with some freedom of choice of activity in living rooms, porches and outdoor exercise areas, as parts of each nursing unit, will require less safety and security than, for instance, the multi-story building in which, generally, the patient has less freedom of movement and so must be conducted to different areas for the various activities.

The following are the requirements of materials and finishes for the various facilities of nursing units.

In the open section, materials and finishes can be as specified for medical and surgical nursing units. There is a large amount of information on current practices and standards for all elements of the general hospital, and those elements, their location, arrangement, equipping and detailing are generally accepted by all professions engaged in their planning and operation. The psychiatric service may satisfactorily adopt many of these accepted elements and details, especially in its open sections.

The following discussion applies principally, therefore, to the locked section, where maximum security and safety should be provided in an unobtrusive manner. Care should be taken to avoid projections of structure, sharp corners, exposed piping, and no design should be accepted which could encourage attempts at hiding, suicide or escape. Simplicity of room arrangement and details is desirable.

Walls, Floors and Ceilings

In the closed section where rooms may be locked at times, local fire authorities should be consulted for the extent of precaution necessary for locked rooms. All structural members should be of noncombustible material. A two-hour fire resistive rating is desirable.

The construction of bedrooms for dis-

turbed patients presents a special problem of noise.* Bedroom wall construction is usually of four-inch hollow masonry block plastered both sides, and this does not always achieve the desired noise reduction. It is obvious that rooms for disturbed patients require an even greater reduction, because of noise transmission generated by impact on wall and floors.

To reduce the transmission of noise caused by impact, into rooms or corridors where it would be objectionable, double-wall construction may be used. A four-inch hollow block wall completely separated from a wall construction consisting of metal studding and metal lath may be used. The block construction should be on the disturbed patient side in order to reduce breakage of plaster surfaces. Where rooms for disturbed patients are adjacent, two separated walls of hollow block may be used.

Floors for disturbed patients' bedrooms also may need special consideration. In new construction, the structural slab may be depressed and a second slab poured over a one-inch thickness of wood or glass fibre, cork board, or similar cushion.

Ceilings do not present a tapping problem, but noise transmission may have to be considered. A suspended ceiling having blanket insulation may be sufficient.

Ceilings should be of acoustical material except in rooms exposed to moisture where they should be of non-absorbent material.

The use of combustible material for finishes should be severely limited. Materials which have low smoke or flame producing characteristics should be used.

Most installations do not include construction in accordance with the above recommendations for floors, walls and ceilings. This may be due to the fact that there will be only a few instances in which such a room will be necessary, as modern treatment programs are effective in rapidly decreasing degree and length of disturbances. The medical staff should assist by determining the extent of the problem as only they will be familiar with the type of patients who may be treated and the treatment program.

Floors for patient areas can be of the same materials as used in other patient rooms. Any type of resilient floor material which is reasonably resistive to indentation is probably the most satisfactory, except for one or two bedrooms for disturbed patients which should have non-absorbent, easily cleaned surfaces.

Screens and Windows

When detention screens are used at window openings, any type of sash or glass may be used. The screen should be mounted flush with the wall surfaces at window head, jambs and sill to eliminate projections on which a patient may be injured. The best installation will provide operation of the sash by a removable crank without opening the screen. Provision should be made for release of the screen from the outside in case of emergency.

When detention screens are not used, windows of sturdy design, operated by removable crank, are recommended. These should be of such design that there is no opening large enough to permit exit, while providing sufficient ventilation. Heat tempered glass should be used to reduce breakage. No window should swing into a room.

Since light may be too stimulating to some patients, it should be possible to darken the room easily. Shutters or venetian blinds should be installed between the detention screen and the sash. Sufficient space should be allowed between the screen and blinds or sash for movement of the screen under stress.

Doors

In the closed section, all doors to patient bedrooms should have vision panels. Doors for quiet and depressed patients may be similar in construction to those in the open section. For disturbed patients, doors should be of sturdy design to resist damage and avoid noise disturbance. Special doors, having insulated wood panels set into solid wood frames, are available, as are metal-clad, solid-core doors. Solid wood doors are probably the most satisfactory from the point of view of appearance and utility, and where disturbed patients' rooms are reached from sub-corridors, are satisfactory for noise resistance. Doors to patient bedrooms should be 3 ft. 10 in. wide.

View panels in patients' bedroom doors should be of heat tempered glass and approximately 8 in. wide by 12 in. long. They should be approximately 4 ft. 6 in. from the floor for ease of observation. Shutters, on the corridor side, should be installed over the view panels.

Doors to the bedrooms may swing in or out. However, while it is true that a patient may barricade a door which swings into a room, in the opinion of many there is better control of the patient with the in-swinging door. There is danger of injury to patients or personnel, or damage to structure or equipment from an out-swinging door which may be thrown open too quickly. Out-swinging doors are more difficult to secure adequately, and where a number of rooms occur along a corridor, they diminish ease of observation of the corridor from a nurses' station.

Doors to bathrooms, closets, patients' laundry room should swing out and be capable of being locked from the outside only. The patients' laundry, utility room, pantry room, entrance and corridor doors should have view panels.

Local fire authorities should be consulted on door swings to rooms which are to be locked. All nursing unit exit doors should swing out.

Heating and Air Conditioning

In the open section, heating may be as specified for the medical and surgical patients. In the closed section, radiant panel heating from floors, walls or ceiling may be used. In disturbed patient bedrooms, radiant heating in the floor is desirable.

Air conditioning in the disturbed patients' area is recommended, both for patient comfort and so that windows may be closed to prevent noise from street or adjacent patient areas.

If radiators are used for heating, they should be recessed into the walls and covered with metal grilles placed flush with wall surfaces. A cove at the interior corner of the jambs, head and sill of the recess will facilitate cleaning.

Electrical Fittings and Hardware

In the disturbed patients' area, recessed lighting fixtures with heat tempered glass covers are recommended. Outlets for floor or desk lamps should be placed 7 ft. 6 in. from the floor. Night lights should have heat tempered glass covers. Nurses' call systems, especially designed for disturbed patients' areas, are being manufactured. Convenience outlets for electric shavers may be provided in the toilet rooms.

In the closed section, doors should have hospital type hinges and roller latches. Single-seated hospital arm pulls, turned down, may be used in the quiet and depressed patients' area. In the disturbed patient area, these pulls may be used on the corridor side of the patients' room and flush cup pulls on the room side. Locks should be dead bolt operated by key only, and it should be possible to lock the patient rooms, bathrooms, storage closets, etc., from the outside only. Interview offices, examination, conference, treatment rooms, etc., should be able to be locked from both sides and by key only. It is recommended to key all locks, excepting drug cabinet, within the closed section to one key. Entrance and exit doors should have a separate key.

* "One Story Hospital Construction," Julian Smariga, Structural Engr., U. S. P. H. S.

See page 8 for model of suggested 100/120 bed R. & I. T. Bldg., made by M. J. Livingstone. Plans available from U. S. P. H. S.
Much of this material is reprinted by courtesy of the ARCHITECTURAL RECORD.

Geriatrics

NEW GERIATRIC BUILDING AT TRENTON, N. J.

Dr. Harold S. Magee, Superintendent of the New Jersey State Hospital at Trenton, announces the opening of a new geriatric building to take 440 male and female patients. The new building known as the "Drake Building" was named for Mr. James F. Drake, a former supervisor of male attendants, who died a few years ago after many years of faithful and efficient service to the hospital.

The two-story building has two T-shaped wings at each end of a central corridor, each "T" section comprising a sixty-bed dormitory, a forty-eight bed dormitory and a day room. Each floor has two seclusion rooms. A central nurses' station commands a clear view of all three sections. Male and female patients are separated by a corridor dividing the building into two sections.

Off the central corridor are separate utility rooms for each of the four wards. Food is brought in from a central hospital kitchen in electrically heated conveyors, received in a service preparation room and distributed from ward diet kitchens. The beverage is prepared on the premises.

The corridors also contain a barber shop, beauty parlor, and occupational therapy and library rooms. A doctors' office is off the central entrance, connecting with an emergency treatment room and a supervising nurse's office. This section also contains a waiting room for visitors.

Wainscotted walls are of soft-tone tile, and the upper walls and ceilings are blond in color. Lights may be dimmed to any degree without switching them off by rheostats.

Disrobing, bathing, clean clothing and dressing rooms are contiguous to allow for easy and efficiency bathing.

Enclosed airing courts were purposely omitted, as it was felt that this would prevent the feeling of confinement and provide a more home-like atmosphere. Adjoining grounds are being landscaped so that ambulatory patients may enjoy lawn privileges in suitable weather.

N.A.M.H. AGAIN HONORS PSYCHIATRIC AIDES

As well as being excellent morale builders, the Psychiatric Aide Awards offered each year by the National Association for Mental Health afford hospital administrators a good chance to arouse the interest of the community in the hospital.

The Awards are designed to increase public appreciation of the vital role the aide plays in the ward care of patients, and by increasing public respect for the position, to increase the recruitment of first-rate people to work in the hospital.

The Awards will be presented by the N.A.M.H. during Mental Health Week, May 2nd through 8th, 1954.

Each eligible hospital in the U. S. and territories has been sent full details as to how to submit the name and achievements of its single most outstanding aide of 1953. Superintendents are reminded that the closing date for such applications is March 15th. Applications should be sent to the N.A.M.H., Psychiatric Aide Achievement Awards, Room 916, 1790 Broadway, New York, N. Y.

where it is super-important to have GARMENT-STRENGTH

Highest resistance to tearing, puncture, abrasion. Reinforced construction at every stress-point; all seams lock-stitched.

APPEARANCE Large selection of quietly colorful patterns on richly mercerized white background; garment design of pleasing detail and proportions.

COMFORT To keep the wearer from becoming uneasily conscious of apparel. Utmost simplicity of dressing; no unnecessary fastening devices.

ECONOMY Moderate initial cost distributes itself over extra *months* of wear! When you need a PROVED-IN-USE *budget-saver*—

...specify Karoll's

supercloth*

expert-planned apparel for men, women, boys, girls—or piece goods.

*pre-shrunk; maximum residual shrinkage 1%

For samples, write or wire

KAROLL'S Inc.

INSTITUTIONAL DIVISION • 32 North State Street, Chicago 2

Functions and Organization of State Mental Health Office

by RALPH M. CHAMBERS, M.D.

Abstracted from Speech made to North Carolina Neuropsychiatric Association at Winston-Salem, Nov. 20, 1953

Each state has an organization which supervises all or part of the functions usually included in a mental health program. Some are separate departments and others are divisions of departments, such as the Department of Welfare or the Department of Institutions. The majority, however, are administered by Boards of different types which have control, either of the mental institutions only or of all the institutions in the state. These Boards usually operate under the direct supervision of the Governor. In some states two or more departments have been assigned duties having to do with mental health.

A properly organized mental health department should be responsible for all mental health activities in the state. When these functions are assigned to two or more departments, there is overlapping of responsibilities and duplication of services. This department should be responsible for the following functions: (a) a statewide mental hygiene program; (b) the operation of an adequate outpatient department; (c) the operation of hospitals and other institutions for the care of the mentally ill, mental defectives, epileptics, psychopaths, drug addicts, alcoholics and psychotic children; (d) educational and research programs; (e) the licensing of all private hospitals caring for the above types of patients; (f) a program of "family care"; (g) psychiatic services required by other state, county and municipal departments including courts, schools and other community agencies.

It should be directed by a commissioner who is a psychiatrist well qualified both by training and experience in mental health administration. He should be assisted by experts in business administration, hospital inspection, extra-mural psychiatry, mental deficiency and epilepsy, statistics and research, social service, nursing, occupational therapy, dietetics, personnel, engineering, construction and agriculture. There should be adequate clerical assistance.

An alternative organization might combine the services of an unpaid board appointed by the Governor and an executive director who would have the same qualifications outlined for the commissioner. The members of such a board should be responsible citizens interested in mental health. They would appoint the executive director and serve as a policy making body.

All appointments should be made for professional reasons and not because of political expediency. The tenure of office should depend upon satisfactory performance. Appointments within the department should be made by the director subject to the rules and regulations of the state civil service.

The director or commissioner should appoint the hospital superintendents, who should be fully qualified psychiatrists with adequate training and experience in mental hospital administration. All appointments to the hospital staffs should be made by the superintendents.

The state should be divided into districts, each of which should have a Mental Health Center with facilities for intra-mural and extra-mural psychiatry. The State Hospital should be an important part of this unit and serve as a headquarters. Clinics should be established in all large centers, and traveling clinics should serve communities not large enough to warrant the establishment of permanent facilities.

Each Mental Health Center would carry out the basic functions of the Department in its own area.

Mental Hygiene Program

The director of extra-mural psychiatry and his assistants can furnish leadership in the mental hygiene program, but most of the work must be performed by interested citizens, adequately organized and trained. These groups should devote time and energy to the education of the general public in the principles of mental hygiene.

Communities not having Mental Hygiene Societies would do well to develop them, for under proper leadership these societies can be very helpful. Churches, schools and courts can make a contribution and members of State Health Councils can be of great assistance.

Volunteer workers can be used successfully in the community, in the clinics and in the hospitals. Auxiliaries, organized for the purpose of furthering the work of the hospital, may also be helpful.

Out-Patient Department

No Mental Health District would be complete without facilities for the treatment of patients suffering from mild mental disorders who are not sick enough to be sent to a mental hospital, those who are developing the early symptoms of a serious mental disorder and many others.

Full time clinics should be established in all important metropolitan centers and traveling clinics should be made available to the small communities. A sufficient number of psychiatrists, psychologists, social workers, psychiatric nurses and clerical workers to do the work comfortably must be available. The clinic should be so located that the patients are not stigmatized by visiting it. A separate building, a general hospital or a health center are usually suitable. Clinics for adults and children should not be held at the same time, and all cases should be referred by a responsible agency. i.e., social agency, court, school, or physician.

The work of these clinics will be, in some cases, confined to diagnosis and recommendations, but since the majority of patients will require treat-

ment by a trained psychiatric team, all clinics should be organized on a treatment level if possible.

The clinics should be used as training centers, and psychiatric residents, physicians and other professional workers in the clinics, the mental hospital and other hospitals should work on a part time basis.

There are some patients who need more treatment than is available in our present out-patient clinics, but who do not require full time hospital care. They do as well or even better under a plan which requires their presence only during the day—the Day Care Hospital. Such facilities should be provided at the Mental Health Center.

Mental Hospitals

A number of patients, because of the nature of their illness, will always require full time hospital care. Consequently, each District should have a modern mental hospital where all forms of therapy are available.

These hospitals should be directed by fully trained psychiatrists who have had adequate training and experience in hospital administration. A staff should be provided composed of competent well trained professionals and other workers in sufficient number to satisfy the standards of the American Psychiatric Association. Facilities for the care of all types of patients—the first-admission patient who requires intensive therapy, patients requiring medical or surgical treatments, those suffering from tuberculosis, the aged, neurological cases and the different classifications that require continued treatment should be included.

Admission Procedures

Admission procedures should be freed from traumatizing routine and be made as simple as possible. Non-judicial admissions are both desirable and practical in most cases. Too often the patient must spend the time in a jail or some other inappropriate institution, while court procedures take place.

When admission for a patient is sought either by a reputable person or the patient himself, he should be admitted immediately as it is almost certain that he is in need of assistance. After admission, physical and mental examinations will reveal his true condition and if he is found not to be in need of hospital care, he can be released.

The facilities of the Mental Health District should be used to the fullest extent in an educational program which should include not only the members of the hospital staff, but the students from neighboring medical schools and colleges. The hospital can supply both instructors and clinical material, and the medical schools and colleges can supply consultants, instructors and teaching facilities not available at the hospital or clinic. Courses for psychiatric residents, medical students, registered nurses, affiliate student nurses and attendants should be provided. Training for social workers, psychologists, occupational therapists, dietitians, theological students, and students in other departments should be provided in cooperation with approved schools, if the necessary instructors can be provided. In-service training for employees in other departments not already mentioned should also be provided.

An alliance with the Medical School and other institutions of higher learning is also necessary to establish an effective research department. A Director of Research in the Department of Mental Health should head and coordinate a state-wide program. The facilities of the department and the educational institutions involved should be used to the fullest possible extent. A member of the staff of each Mental Health District should be appointed to act as liaison officer and to direct the research work in that center.

Private Mental Hospitals

The licensing of private mental hospitals is an important function which should be performed with diligence and care. The fact that a hospital is licensed by the Department of Mental Health serves as a guide to those who must use its services and as a protection to those who are responsible for its management.

Although the Mental Health Center should be directly responsible for a family care program in its district, it will be necessary to have supervision by the central office to insure continuity and uniformity.

Psychiatric services are frequently required in courts, prisons, schools and other organizations within the state, county and municipal set-ups. The Department of Mental Health should be responsible for furnishing these services in cooperation with these organizations.

Financial Support

Such a program cannot survive without adequate financial support. Appropriations for maintenance must be made annually and must be sufficient to cover the cost of operating the different divisions of the department. Appropriations for new buildings and major repairs, commonly called capital expenditures, should be made when the need becomes apparent. Deferring such appropriations until conditions become so acute that public opinion forces the issue should be discouraged, because a large sum of money is difficult to spend effectively in the short time usually allowed. Smaller sums appropriated as the need arises makes possible the orderly accomplishment of a long range program and prevent ravages due to overcrowding, poor maintenance, and lack of facilities.

Volunteers

CHURCH GROUP AIDS SPECIAL PROJECT

Modesto (Calif.) State Hospital's experiment in setting aside two "privileged" cottages for better-grade mentally deficient women patients is being aided by a local church group. The Modesto Presbyterian Ladies donated furnishings and accessories for the cottages. They installed dressing tables, mirrors, bedspreads, curtains, rugs, pictures, and cosmetics.

Once a month they take three or four of the patients to their church luncheon. They plan to take each of them out for a day occasionally, and help them with such things as manners and social skills.

"The Presbyterian Ladies have an unusually large church group—about 350 are active in this work," says the hospital administration. "They are a model volunteer group and a real asset to the hospital."

THE PATIENT DAY BY DAY

Occupational Therapy

ORT CENTER DEDICATED AT ILLINOIS HOSPITAL

Illinois welfare officials attended the ceremonies in December to dedicate the opening of Manteno State Hospital's new ORT building. The new facility is known as the Forbes Center, in honor of Mrs. Ethel Forbes, who has been an Occupational Therapist in Illinois state hospitals since 1927 and in charge of Manteno's ORT program since 1942.

The C-shaped brick building houses all the major activities of the hospital's Occupational and Recreational Therapy Department. There are seven classrooms for handcraft and artwork. Each accommodates 28 patients and folding doors between the rooms permit the space to be used as one continuous area or subdivided into from one to seven smaller areas. Each unit is provided with running water and has floor-to-ceiling cupboard and drawer space, and built-in coat racks.

There are three other classrooms, equipped for specific OT activities. The ceramics room has an electric kiln with automatic timing and thermostatic control, an electric oven for plastics and a potters wheel. The art and basketry unit contains tanks for soaking reeds and willows, and a large sand table in which to make model villages. The third room is equipped for woodworking, having nine work benches, a motor-driven jigsaw, sander, and drill press.

The soundproof music room is large enough to accommodate a full band, orchestra or choral group, and has five soundproof practice cubicles. It is equipped with an electric organ, pianos and an electric vibra-harp. Storage space is provided for instruments, uniforms and orchestrations.

Large windows line the 12,000-volume library which is designed to accommodate 150 patients at a time. It is decorated by plants and an aquarium. Just off the library is a bookbindery. The corridor outside the library has display cases for exhibiting the articles made by the patients.

One wing houses the auditorium and adjunct facilities. The auditorium can accommodate 400 persons at a gathering, or can be divided into three smaller game areas by use of two sets of folding doors. At one end is a movable stage. Adjoining that end is a large storage room for costumes and scenery, which also contains wash tubs and ironing boards for laundering costumes.

The building contains three offices for the ORT administrative staff and two industrial therapy offices, a supply room which has lazy-susan supply counters, a complete photographic darkroom, toilet facilities, and an employees' lounge. This room is equipped with lockers and a refrigerator, stove and coffee-maker for the employees to use at lunchtime. Occasionally small patient groups will be permitted to prepare their own refreshments there also.

The chaplaincy program also has been provided for in the new building. There is an office for the resident Protestant chaplain, one for the Catholic chaplain and another for visiting ministers, in addition to a conference room for theological students in clinical training at the hospital.

Outside, on the south side of the building, is a paved and landscaped game patio, suitable for shuffleboard, dancing, roller skating and ice skating.

O. T. DISPLAYS AROUSE PUBLIC INTEREST

An exhibition of articles made by patients in Occupational Therapy classes at Nevada State Hospital attracted considerable public interest, reports the hospital's Superintendent, Dr. Sidney J. Tillim. Last fall the hospital had a booth at the local County Fair to display O.T. products and shortly afterwards, an exhibit at the public library. As a result the hospital received offers of O.T. equipment and materials.

Dr. Tillim feels that Occupational Therapy lends itself especially well to public education efforts, as it is one of the more tangible and understandable examples of service to patients.

Clinics

LETTER TO THE EDITOR

The Editor, MENTAL HOSPITALS
Dear Sir,

I would like to clarify one or two statements made in your article entitled "Hospital Staff Members Aid School Project Clinic," published in the January issue of MENTAL HOSPITALS.

The Kiwanis Clinic was organized, not for the prevention of juvenile delinquency, but because of the vital need of the local public schools for psychiatric services to emotionally disturbed children, together with the need for teacher education in mental hygiene principles. We are, however, examining and treating students who might otherwise show behavior incidental to juvenile delinquency.

We hold clinic sessions two evenings a week—the diagnostic section on one evening and the treatment section on another. The Clinic is located in the senior high school building.

Following the appointments with the psychiatric social worker and the clinical psychologist, the patient is examined by the psychiatrist member of the team. (The expression "a three-member therapy team" is misleading.) The case conference then follows and if therapy is recommended, the case is transferred to the therapy section, where the patient is scheduled for individual psychotherapy as the caseload permits.

Extended individual psychotherapy is given only by the psychiatrists assigned to the treatment section. However, several members of the diagnostic teams do carry a patient or two for brief therapy and counseling (always under medical supervision).

An innovation was begun this year where a member of the diagnostic team meets with the student's teachers and counsellors at his school for a general discussion of the case and to interpret the recommendations of the Clinic. This serves as a popular and apparently very good educational mechanism.

ADDISON M. DUVAL, M.D.
Director, Kiwanis Clinic.

Dietetics

N. J. HOSPITAL FINDS ECONOMY IN PURCHASE

After analyzing the cost of making doughnuts and ice-cream for its 4200 patients, the Trenton (N.J.) State Hospital has found it more economical to purchase these products. Mrs. Claire Waldron, Head Dietician at the hospital, reports that they discovered it cost them 26 cents a dozen to make doughnuts in the hospital bakery. This figure was based on the cost of labor and materials only, and did not include overhead expenses.

Several commercial bakeries were invited to submit bids and samples. A "taste-testing committee" selected one which was offered at 25 cents a dozen delivered to the individual kitchens. Mrs. Waldron says they have proved not only more economical and better tasting, but that the 12 to 14 hours it required for a paid baker and two patient-helpers to turn out the doughnuts each week is now given to making rolls and pies thus adding variety to the diet.

Similarly, they found that they could purchase ice-cream for 28½ cents a quart, compared to 30¢ a quart for hospital-made ice-cream.

HAROLD S. MAGEE, M.D.
Supt., Trenton (N. J.) State Hospital

Legislation

N. J. LAW PERMITS REMOVAL OF COMMITMENT RECORD

An Act passed by the 1953 New Jersey Legislature provides that any person discharged as recovered from a mental institution may, ten years after final discharge, petition the court to expunge the commitment from the court records. After the court sets a hearing date, notice is given to the county adjuster and to the medical director of the institution concerned.

The law pertains to both court and voluntary commitment, but not to the commitment of a criminal defendant resulting from a decision that he was not guilty by reason of insanity.

SAFE, SANITARY WASH FIXTURES

Central Sprayhead Replaces Faucets

For inmates and institution personnel —Up to 10 wash simultaneously

Durable and safe, Bradley Washfountains provide the utmost in sanitary washing facilities. . . . Foot-control eliminates need for faucets—up to 10 persons are served tempered water simultaneously with no chance of scalding.

Water supply is cut off immediately foot is removed from control-ring at base of Washfountain. Widely used in institutions, sanitaria, hospitals, schools—57 Washfountains in the California State institution illustrated above. Write for Catalog 5204. BRADLEY WASHFOUNTAIN CO., 2317 West Michigan Street, Milwaukee 1, Wisconsin.

BRADLEY washfountains

Write for Catalog 5204

Distributed Through Plumbing Wholesalers

People & Places

Dr. Walter Rapaport, previously Superintendent of Agnews (Calif.) State Hospital was named Director of Mental Hygiene for California. Dr. Ewing H. Crawfis, who held the position for a few months following Dr. Frank Tallman's resignation, has resumed his former post as Deputy Director of Medical Services in the Department. . . . Dr. R. S. Rood was appointed to head California's new maximum security hospital, under construction at Atascadero. His previous position as Superintendent of Mendocino State Hospital was assigned to Dr. Daniel Lieberman, Assistant Superintendent of Sonoma State Hospital. . . . Also in California, Dr. Thomas W. Hagerty retired as Superintendent of the Stockton State Hospital, and was replaced by his Assistant, Dr. Freeman H. Adams. . . . The new Superintendent of Kankakee (Ill.) State Hospital is Dr. Cleve C. Odom, who previously headed the Arkansas State Hospital at Little Rock. He replaces Dr. Ernest Klein, who has become Assistant Superintendent of Elgin (Ill.) State Hospital, succeeding Dr. Daniel Haffron, now Superintendent of Elgin. . . . Dr. Alfred Paul Bay accepted the superintendency of Topeka (Kans.) State Hospital after resigning as head of Manteno (Ill.) State Hospital. Dr. Charles K. Bush, Superintendent of Dixon (Ill.) State School was named Acting Superintendent of Manteno. . . . Dr. Duncan D. Campbell replaces Dr. Edward F. Dombrowski as Superintendent of Chicago (Ill.) State Hospital. Dr. Campbell formerly served as Assistant Superintendent. . . . In Massachusetts, Dr. Peter B. Hagopian was appointed Superintendent of the Danvers State Hospital, succeeding Dr. Clarence A. Bonner, who has retired. Dr. Hagopian was Assistant Commissioner of Mental Health. . . . Ohio has opened a new, 128-bed receiving hospital at Toledo State Hospital, and has two others under construction: the Hamilton County Receiving Hospital at Cincinnati, and Scioto Receiving Hospital at Portsmouth. The latter facility, of 140 beds, is due to open shortly. Its Superintendent will be Dr. Thomas A. McMahon, Assistant Superintendent of the Apple Creek State Hospital.

M. H. S. News & Notes

Volunteer Groups Working with M.H.S.

Requests have come in from time to time from Superintendents of State hospitals as to guidance in setting up well-planned and productive volunteer programs in their hospitals.

The Medical Director has accordingly authorized the Mental Hospital Service to work with the National Headquarters of the American Red Cross, the Veterans Administration Voluntary Service and other interested volunteer groups, with a view to surveying the present situation, in the field so that recommendations and help can be given in concrete form, not only in the setting up of new programs, but in the improvement, if required, of existing programs.

It should be emphasized that M.H.S. is working with all interested organizations and that the final recommendations will apply, not only to the work of any one or two specific voluntary organizations, but of all community groups and individuals who work in your hospitals.

Food Committee Started

The first meeting of a new Mental Hospital Service working committee was held at the A.P.A. offices on January 19th. This committee is jointly sponsored by the A.P.A. Mental Hospital Service and the American Dietetic Association, and its purpose is to help hospitals to improve their dietetic standards.

Specific tasks to be undertaken by the Committee include the offering of assistance to the A.P.A. Committee on Psychiatric Hospital Standards and Policies; to make recommendations regarding kitchen and dining areas, and equipment for various types of facilities to the Architectural Study Project; to work out a basic ration allowance suitable for our patients and to edit the recipes sent in from hospitals all over the country, for publication and distribution to member hospitals.

Members of this joint committee are: Dr. John L. Smalldon, Director of the Architectural Project, who will be the joint chairman with Miss Clarice Gullickson, VA Dietetic Service; Dr. Ralph M. Chambers, A.P.A. Central Inspection Board; Dr. Lucy Ozarin, Chief, VA Hospital Psychiatry (as liaison with the A.P.A. Psychiatric Hospital Standards & Policies Committee); Dr. Theodore L. Dehne, Superintendent, Friends Hospital, Philadelphia, Pa.; Mrs. Una Powell, Food Service Supervisor, Virginia Dept. of Mental Hygiene & Hospitals; Miss Frances Gibson, Dietitian, Spring Grove State Hospital, Catonsville, Md., and Mrs. Doris Sutton, Dietitian, St. Elizabeths Hospital, Washington, D. C. All the dietitians on the committee are members of the A.D.A.

At this meeting, specific tasks were assigned to psychiatrist - dietitian teams, each of which will make a report on its work at the next meeting to be held early in March.

The Committee went on record with the statement that patients in any mental hospital are entitled to good food, no matter what their previous standards have been. Everybody in the institution, from the superintendent to the garbage collector, must be vitally interested in food problems, if this goal is to be attained.

In pursuit of this aim, the Committee formulated the following recommendations:

1. Each hospital should have a fully organized and unified dietetic department, headed by a professionally trained administrative dietitian who has the full cooperation of the medical and business departments.

2. Food preparation and service facilities must be adequate.

3. There must be sufficient well-trained employees selected by the head of the department. They should be trained not only in good dietetic practices but also in dealing with mental patients.

4. A basic ration allowance should be established, for the present time to meet at least the standards established by competent authorities. Under the present "per patient, per diem cost" system, nutrition goes down when price goes up.

5. All foods should be purchased according to standard specifications and these specifications should be maintained by qualified inspectors and laboratories.

6. Carefully planned menus should meet nutritional and psychological needs.

7. A variety of foods with consideration of regional preferences will not only add to the pleasure of the meals but will also help to eliminate waste.

8. All foods must be carefully prepared under sanitary conditions. Correct processing and cooking methods must be followed under proper supervision.

9. Food must be served as soon as possible after cooking.

10. Each meal should be a pleasant experience to which the patient can look forward. The importance of attractive service in pleasant surroundings cannot be over-emphasized.

The Committee invites comments, suggestions and criticisms from doctors, dietitians, business managers and any other hospital or State Department worker who is interested in improving the food standards.

1954 Achievement Awards

This is to remind superintendents that applications for the A.P.A.-M.H.S. Achievement Awards are now being received. The closing date is March 31st, 1954.

Apart from the covering letter which must be sent with the description of the achievement of the hospital, no application form is required. Instruction sheets were sent with the January issue of MENTAL HOSPITALS, but if any hospital has mislaid the sheet, another may be obtained from M.H.S. Please send stamped, addressed envelope.

This Achievement Award contest must not be confused with the N.A.M.H. Psychiatric Aide Awards which are announced on Page 15.

Mental Defectives

STATE SCHOOL OFFERS OPTIONAL EVENING CLASSES

The Parsons (Kans.) State Training School has added an evening schedule of educational and recreational activities to its stepped-up training program. Classes are given in civics, health and nature study. Audio-visual aids are used extensively, and attendance is voluntary. Along extra-curricular lines are the psychodrama sessions and arts and crafts lessons.

The evening recreation program includes a weekly dance, community sing and movies and a monthly skating party at a local rink. In addition, the student canteen is open Saturday nights, and it has television, a soft drink fountain and a lounge area.